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ROCKY MOUNTAIN SPOTTED FEVER IN RHODE ISLAND

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Of unusual academic interest and considerable epidemiological significance is the appearance of two cases of Rocky Mountain Spotted Fever in Rhode Island. The diagnosis of the two cases has been confirmed clinically and serologically. Both cases have been hospitalized at the Charles V. Chapin Hospital. According to information received at the Bureau of Preventable Diseases, Rhode Island Department of Public Health, these are the first instances of the disease in New England. Investigation shows that the onset of the disease in both cases followed tick bites received while the patients were summer visitors in East Brewster, Massachusetts. The case reports are as follows:

CASE 1. H. D., age forty-nine, white, married, native born and a police officer by occupation. Was admitted to the Charles V. Chapin Hospital on July 26, 1937 with the chief complaint: headache, abdominal pain and persistent constipation for six days prior to the hospital admission.

On July 8, 1937, the patient accompanied by his wife went for a vacation to the town of East Brewster on Cape Cod, Massachusetts. The house at which they stayed was unoccupied by any other person during the visit. There were no cats, dogs or other animals on the premises. Neither were there any signs of rats or mice in the immediate vicinity of the house. While staying here the patient and his wife visited a private beach, owned by the proprietor of the house, practically every day. Wood ticks were present in abundance in the grass and scrub growth about this beach.

On July 15th or 16th while lying on the beach in a bathing suit the patient received a tick bite on his left forearm. This was the only tick bite recalled by him. He had no recollection of the length of time the tick had been attached to his forearm. At first he thought it to be a "scab" and picked it off with some difficulty. After picking it off he killed it by squeezing it sideways between his fingers. The bite did not become infected. During the next few days he felt "dopey" and "lacking in pep."

On July 20th toward the end of the afternoon the patient was seized suddenly with a frontal headache and his abdomen felt as though it were "blown up like a balloon" and "tender all over." He felt general aches and pains in the back and legs. Loss of appetite was marked and there was some nausea but no vomiting. For over a week following the onset of these symptoms the patient did not take any solid food.

On the night of July 20th he had a chill which was followed by profuse sweating.

On July 21st he felt restless and was in and out of bed all during the day. In the morning he noticed for the first time a rash which already had covered his entire body from the neck down. The bowels did not move and the abdominal distention continued. Chills followed by profuse sweating continued.

On July 23rd his condition being unchanged, patient and his wife were driven back to Providence in an automobile by his son. At this time he felt very dry and thirsty and drank a great deal of water.

On his return to Providence he was seen by one of us (E. A. McL.). An enema was given which partly released the abdominal distention but produced little fecal result. Previous to the present illness the patient was inclined to be constipated and maintained some degree of regularity of the bowels with the use of Sal Hepatica. Since the onset of the present illness no cathartics had been taken and the bowels did not move for six days.

On the afternoon of July 23rd temperature was 102 degrees F. For the next day there was little change except that patient vomited once during the afternoon. Temperature remained at 102 degrees.

On July 26th prior to his admission to the Charles V. Chapin Hospital temperature rose to 103 degrees. The throbbing headache and constipation had steadily increased and there was considerable malaise and the patient complained of insomnia. There had been a slight cough with pro-

duction of a whitish phlegm. There had been pains in the left upper quadrant along with the feeling of abdominal distention.

He stated that he had not eaten shellfish of any kind. In Providence he was in the habit of drinking water only from the city supply. In East Brewster he drank water from an artesian well. He used only pasteurized milk and had not wittingly been in contact with typhoid carriers. The family history, marital history and social history were negative.

Past History

Measles in childhood.
Diphtheria in 1920.
Quinsy sore throat in 1921.
Motor vehicle accident in 1921 in which he suffered broken bones in his left hand and left foot. Great toe of the left foot amputated.
Tonsillectomy in 1921.

Physical examination on admission showed the entire body from the neck down to be covered with a discrete reddish macular-papular eruption. Some of these lesions were barely palpable; others were not. Some blanched with pressure; others did not. The distribution was fairly uniform on the flexor and extensor surfaces and on the trunk and extremities. The lungs showed a few fine rales in the bases. The abdomen was distended with gas. The liver and spleen were not felt but tenderness was elicited over the splenic region. There was no costovertebral tenderness. The tentative diagnosis on admission was (?) typhoid fever.

Laboratory Studies

Urinalyses in four examinations, July 27th to 30th, showed albumen slight trace on two occasions. Frequent red blood cells and white blood cells on one occasion. Rare red blood cells and rare hyaline and granular casts on one occasion.

Cultures for typhoid and dysentery were negative.

Spinal fluid studies essentially negative.

Wassermann and Hinton negative.

Repeated blood cultures were sterile.

Blood picture on July 26, 1937

Hemoglobin	85 (Tallquist)
Red blood cells	5,160,000
White blood cells	11,550
Polymorphonuclears	75%
Lymphocytes	20%
Monocytes	5%

Widal for typhoid and paratyphoid negative. On July 26th by rapid slide negative.

Undulant fever (Huddleston) negative on July 26th.

Blood chemistry on July 26th.

150 sugar
39 N. P. N.

Stools on three examinations were negative for typhoid and paratyphoid bacilli.

Nose and throat cultures were negative.

Skin test on August 3rd negative for undulant fever.

Blood picture on August 6th

White blood cells	8,200
Polymorphonuclears	44%
Lymphocytes	49%
Monocytes	5%
Eosinophiles	2%

Weil-Felix Reaction

Prior to the hospital admission on July 26th and at the request of the Department of Public Health, a sample of blood was obtained and sent to the Conn. State Health Laboratories for consideration of Rocky Mountain spotted fever or typhus fever as possibilities.

1. Connecticut State Department of Health Bureau of Laboratories. July 26th.
   3 plus agglutination in dilutions 1:20 and 1:40
   2 plus in 1:80 dilution
   1 plus in 1:160 dilution
   ± in 1:320 dilution
2. Harvard University Medical School Department of Bacteriology and Immunology (Dr. Zinsser). August 4th.
   Agglutination in 1:2500 dilution with OX19
   In 1:320 with proteus OXK
3. U. S. Public Health Service. August 11th. National Institute of Health (Dr. R. E. Dyer).
   Agglutination in 1:25,560 dilution with proteus OX19

On August 10, 1937, Dr. Hans Zinsser of Harvard Medical School visited the patient and stated that in his opinion the case belonged to the Rocky Mountain Spotted Fever group of diseases, rather than typhus fever.

Course in Hospital

On admission the temperature was 102 degrees F., pulse 100, respiration 30. Temperature exhibited morning remission and evening exacerba-

tion. Normal on August 5th, remaining normal since that date.

At this time (August 17, 1937) the eruption is still found to persist with characteristic appearance about the ankles and feet.

CASE 2, WIFE OF CASE 1

Admitted to the Charles V. Chapin Hospital on July 31st for observation. On admission she had a temperature of 102.4 degrees F., pulse 130, respiration 20. Chief complaint: headache and generalized eruption of four days duration. She was assertedly in good health until July 18th, when she was bitten by a wood tick while spending her vacation in East Brewster. The tick had attached itself to a toe on her right foot and had remained there for several days before being pulled off with difficulty.

On July 24th while caring for her sick husband she began to have generalized malaise and fatigue.

On July 27th she developed a severe frontal headache and a generalized rash over the body from the neck down. The rash was similar in distribution and appearance to that of her husband, whose rash had developed about one week earlier. Since the onset of her illness fever had been as high as 104 degrees. The patient recalls that the tick bite on a toe of her right foot had become infected. There were no other symptoms except for a "running" and partially obstructed nose accompanied by a slight sore throat. There were no gastrointestinal or genito-urinary systems. Generalized aches and pains were present, particularly, over the small of her back.

Past History

Diphtheria and scarlet fever.

On admission patient presented a macular-papular reddish eruption over the body. The lesions were discrete, the average size being approximately one half a centimeter in diameter. There were comparatively few lesions on the trunk. The elbows and knees were mostly affected. There were some lesions on the palms and soles. All lesions blanched with pressure. The flexor and extensor surfaces were equally affected. There was a soft systolic murmur at the apex of the heart. The extremities were normal except for a crust at the site of the tick bite on a toe of the right foot.

Laboratory Findings

Blood cultures while at the hospital repeatedly negative.

Urine has been negative.

Blood Widal rapid slide agglutination test on August 6th showed positive with typhoid "0" in 1:20 dilution and weakly positive in 1:40 dilution.

Blood serology for Undulant fever showed 1:25 dilution weakly positive and 1:50 dilution very weakly positive. 1:100 negative 1:200 negative.

Wassermann and Hinton test negative.

Skin test for undulant fever on August 3rd (?) slightly positive.

Weil-Felix Reaction

1. Harvard Medical School
   Department of Bacteriology and Immunology (Dr. Zinsser)
   August 4th. Weil Felix Reaction Positive in 1:320 dilution with Proteus OX19 and OXK.
2. U. S. Public Health Service
   National Institute of Health (Dr. Dyer)
   Positive in 1:2500 dilution. August 10th. The strains used were B. proteus OX19 and OXK.

In the opinion of the National Institute of Health the history, clinical findings and laboratory results were consistent with a diagnosis of Rocky Mountain spotted fever.

During the week of August 16th, with the cooperation of the local board of health in East Brewster, Massachusetts, three ticks were collected and sent to Dr. Zinsser's laboratory at the Harvard Medical School. These ticks were identified by the state entomologist as *Dermacentor variabilis*.

Comment

Several interesting points have been brought up in connection with these reported cases. Communications with the state health officers of the New England states, and with Dr. Hans Zinsser of the Harvard Medical School and Dr. R. E. Dyer of the U. S. Public Health Service have indicated that these are the first definite cases of Rocky Mountain spotted fever to be reported in New England. The clinical pictures and laboratory findings have been entirely consistent with the diagnosis. The history of tick bites, incubation period and symptomatology are in complete accord with our knowledge of the disease. Many interesting channels of speculation are present with reference to the occurrence of these cases. Why should the disease have singled out two out-of-state summer visitors? Careful questioning of neighbors in the community reveals that tick bites are quite common in the locality yet

no cases of the disease had ever been reported in the past. Is it possible that infective ticks have been brought into the locality from residents in other sections of the country? Perhaps through the medium of tourists or animals? Could native ticks have been infected through contact with persons from other states where the disease is prevalent? It is known that about the time of the probable infection in the two cases, a number of boys from states in which the disease has been reported, were spending their summer at a private camp located about one quarter of a mile from the house and beach used by the cases. These and other questions remain to be answered.

*A brief review of the history of Rocky Mountain spotted fever shows that it was known to have occurred among white people of the Rocky Mountain region in Montana and Idaho as early as 1885. It is quite probable that the disease existed among Indians before that time but accurate data on that point are not available. It had been observed that the disease occurred during the season of greatest prevalence of wood tick. The disease has occurred more commonly among those whose occupation exposed them to the bites of ticks and in the majority of cases the history of tick bite was obtainable. In 1906 Ricketts began studies which demonstrated the presence of infected wood ticks in nature and the hereditary passage of the virus from one generation of the tick to the next. King and Ricketts independently were successful in transmitting spotted fever to guinea pigs by the bite of ticks. Since that time it has been found that several of the species of ticks found in this country are capable of transmitting the disease.

In 1908 the distribution of Spotted Fever as known in the United States included the states of Idaho, Missouri, Wyoming, Nevada, Oregon, California, Washington, Colorado and Utah. It was noted at that time that the disease was rather sharply localized in certain small areas in the Northwestern states. This same tendency to localization in fairly well circumscribed areas has apparently remained as an epidemiological characteristic of the disease to this day.

In the twenty years following 1908 cases of the disease were also recognized in South Dakota and North Dakota. One case was reported in Indiana in 1925. A case was reported in New York in 1925 and the diagnosis of Spotted Fever considered. This diagnosis was ruled out largely on the ground that spotted fever had been reported only from a limited locality. Spencer reported a case of typhus-like fever following tick bite which occurred in Norfolk, Virginia, in 1926. It would appear in the light of our present knowledge, that the New York case and the Norfolk case were both spotted fever.

At this point it might be of interest to state that cases of typhus-like fevers occurring in the Eastern states could be divided into two groups epidemiologically. One group was predominantly an urban disease of urban origin. The second group comprised those cases of Rocky Mountain spotted fever which were rural in origin. These latter cases in an significantly high percentage followed a tick bite after a short period of incubation.

Many observers have noted that the season of incidence of the rural cases corresponds closely to the presence of a common tick in the region where the cases occurred.

The tick *Dermacentor variabilis* is closely related to the tick responsible for the Northwestern cases of spotted fever.

Blood drawn from the spotted fever-like cases in the East and injected into laboratory animals produced a disease in these animals which was found by Badger of the U. S. Public Health Service to be identical with spotted fever in all particulars save for the absence of scrotal inflammation in male guinea pigs.

The Eastern strains of spotted fever like the Western strains do not immunize against typhus fever.

It has already been pointed out that incidence of spotted fever in the West and in the East corresponds to the tick season in the two sections. In the East *Dermacentor variabilis* appear in March and are more prevalent from the middle of May to the middle of July. Occasionally they are found as late as October or November. Spotted fever in man in the East has been reported from March to December with the greatest incidence in June and July. The Eastern states which have reported cases of spotted fever prior to the Rhode Island cases are New York, Pennsylvania, Maryland, Virginia, Delaware, New Jersey, North Carolina, South Carolina, Georgia, Tennessee, Texas, Louisiana and Oklahoma and the District of Columbia.

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*From the Kober Lecture for 1933.

By R. E. Dyer, Surgeon, U.S.P.H.S.

Subject: Typhus and Rocky Mountain Spotted Fever in the United States "Military Surgeon" June, 1933.

Studies of the serum from our own reported cases are being conducted in the laboratory of Dr. Hans Zinsser of the Harvard Medical School. Department of Bacteriology and Immunology and at the National Institute of Health of the U. S. Public Health Service.

In addition, Dr. Zinsser will conduct studies in ticks collected in the neighborhood of the camp in Brewster, Massachusetts, in an effort to get a virus. Also, an investigation will be made for rat infestation in the vicinity. Rats will be trapped in an effort to collect fleas and studies of these insects will be made for determining the presence of virus. The studies of Marshall Hertig and his co-workers at the Harvard Medical School have shown that the meadow mouse commonly found on Cape Cod, Nantucket and Martha's Vineyard, serves as a reservoir host for larva, or "seed tick," and nymph stages of the *Dermacentor Variabilis*. Consequently this rodent will also be trapped in an attempt to isolate the virus from these young stages of the insect.

The annual Clinical Congress of the Connecticut State Medical Society which was attended last year by 633 physicians from ten states will be held this year in New Haven on Tuesday, Wednesday and Thursday, September 21, 22, 23. The registration fee for the entire Congress will be $2.00. The morning sessions beginning at 9:30, will be held in the auditorium of the Sterling Law Buildings. The afternoon and evening sessions, beginning at 2:15 and 8:15 respectively, will be held in the buildings of the New Haven Hospital and the Yale School of Medicine. The evening meetings are section meetings which are open to all members of the Congress.

Complete program and registration card can be obtained from the Chairman of the Committee on Publicity and Registration, Dr. Maurice J. Strauss, 41 Trumbull Street, New Haven, Connecticut.

The Fifteenth Annual Meeting of the Academy of Physical Medicine will be held at the Hotel Walton, Philadelphia, October 19, 20, 21, 1937.

A copy of the program may be had by addressing:

William D. McFee, M.D., *Chairman*
Committee on Program and Publication,
41 Bay State Road, Boston, Mass.

AFFECTIONS OF THE COLON, THEIR CLASSIFICATION AND DESCRIPTION

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Today it is my purpose to attempt to present my conception of the clinical entities affecting the large bowel. In this attempt I shall first outline the clinically important affections in the following charts. Then brief descriptions of these important clinical entities will be given.

Primary Diseases of Colon

Diverticulosis and -itis
Polyposis
    Congenital
    Acquired
Carcinoma
    Right colon
    Left colon
Colitides
Fistula
Megacolon
Sarcoma
Benign tumors
Granuloma
    Specific: lues, tbc., actinomycosis
    Non-specific:
Parasitic infestations
    Amoeba, giardia, tapeworm
Bacillary dysenteries
Volvulus
Intussusception
Appendicitis
Appendices epiploicae; affections

Secondary Disorders of Colon

Functional origin
    Spastic colon
    Atonic colon
    fecal impaction
    constipation
Irritable bowel

Read before the Rhode Island Medical Society at the One Hundred and Twenty-sixth Annual Meeting, Providence, June 2-3, 1937.

Charles W. McClure, M.D., Gastroenterologist to the Fifth Medical Service and Junior Visiting Physician, Boston City Hospital. Assistant Professor of Gastroenterology, Boston University School of Medicine.

John Zielinski, M.D., Resident Radiographer, Boston City Hospital.

Disorders of the Rectum

Strictures, new growths, polyps, prolapse, ulcerations, inflammations, foreign bodies, lymphopathia venerea.

Disorders of Anus

Infections, spasm, fissure, ulcer, stricture, anal eczema and pruritus ani, hemorrhoids, fistula, syphilis.

DIVERTICULOSIS AND DIVERTICULITIS:—Diverticulosis is the result of evaginations, out-pouchings, of the wall of the colon forming sacculations. These saccules vary in number and size; their average diameter is about a centimeter. 80% of diverticula occur in the sigmoid. They are most common after the age of 40, and 70% of them occur between the ages of 50 and 70. The demonstration of the presence of diverticula depends on the x-ray. Their presence is an indication for a bland diet, mineral oil and avoidance of cathartics and enemata.

Diverticula become of clinical significance in about 1/5 of the cases because they become inflamed. The resulting diverticulitis may be acute or chronic. Since both a diverticulum and the appendix are sacculations, the symptoms of inflammation of either are similar. A salient differential diagnostic feature is that diverticulitis usually occurs in the sigmoid and therefore the symptoms are most frequently localized in the left lower quadrant. Also, as in appendicitis, the symptoms of diverticulitis vary from mild to very stormy. There may be merely discomfort; or there may be sharp pain, localized tenderness and muscular rigidity, fever, leucocytosis, nausea and vomiting.

The treatment of diverticulitis is expectant; i.e., you expect the patient under rest in bed to get better or worse. If he gets worse it is usually due to (1) acute perforation, (2) abscess formation, (3) fistula formation either vesical or intestinal, or perhaps external, and single or multiple in number, (4) inflammatory obstruction, or (5) malignant degeneration.

POLYPOSIS:—In addition to true polyps small benign growths such as adenomas, papillomas, fibromas etc., which project into the lumen of the bowel are loosely called polyps. Polyps are either congenital or acquired. The acquired result from some inflammatory process and are especially common in odd cases of ulcerative colitis. Multiple polyposis, or more correctly diffuse adenomatosis, of congenital origin is found in adults most frequently between 30 and 40 years of age. Carcinoma eventually develops in about 50% of these cases. Multiple polyposis (polypoidosis) gives rise to colicky abdominal pain and diarrhoea and the stools may contain bloody mucous. In such cases loss of strength and weight are common; while anorexia, nausea and vomiting are occasionally present. Complications which occur are ulceration, intestinal obstruction, intussusception, secondary anemia and malignant degeneration.

The diagnosis of diffuse adenomatosis of the rectum is readily made by a digital rectal examination. However, the most effective means of finding polyps in the rectum or sigmoid is by means of the sigmoidoscope. The demonstration of polyps in other parts of the bowel depends on special x-ray technic. "The frequency with which single or multiple polyps are found in the colon and rectum is in direct proportion to the care and assiduity with which one seeks them."

It is wisest to consider all polyps, whether true or false or single or multiple, as potentially malignant. Thus the treatment is always surgical.

CANCER OF THE COLON:—Cancer of the colon presents variable clinical pictures because of differences in the physiology and pathology of the right and left halves of the colon. The function of the right colon is absorption, the feces are liquid, the cancers are of the raw surface, ulcerating, medullary type and the symptoms are essentially toxic. The function of the left colon is excretory, the feces are solid, the cancers are of the scirrhous type and the symptoms are essentially obstructive.

The toxic symptoms of cancer of the right colon may be briefly grouped as follows—(1) irritable colon; (2) pain or distress resembling (a) acute, subacute or chronic appendicitis, (b) gall bladder disease, or (c) atypical peptic ulcer; (3) profound secondary anemia. A palpable mass in right lower quadrant is often found accidentally by the patient or the examining physician.

The obstructive symptoms of the left colon may be acute; when due to foreign body, volvulus or intussusception. The chronic obstructive signs are irritable colon, visible peristalsis, pain.

The diagnosis of cancer of the rectum and colon is made by digital rectal examination, sigmoidoscopy and by x-ray barium enema.

COLITIS:—Colitis is frequently confused with irritable bowel, spastic colon, and various other conditions which affect the colon. The abuse which

the term colitis so commonly receives makes it apparent that knowledge of its true character is not sufficiently widely disseminated. The term colitis represents definite disease entities in which there occur well-defined pathological changes in the mucous membrane of the large bowel. Inflammatory changes may secondarily involve the entire gut wall. The inflammatory changes in the mucous membrane in colitis are of catarrhal, purulent, sangineous or ulcerative character. Their causes are outlined on the chart which follows:

Colitides

- Infections
  - Infectious Diseases
  - Syphilis
  - Amoeba
  - Intestinal Parasites
- Foods
  - Irritants
  - Fruit juice
  - Cellulose
  - Decomposition
  - Fermentation
- Deficiencies
  - Minerals
  - Vitamins
- Poisons
  - Metallic
    - Lead
    - Mercury
  - Organic
    - Ptomaine
- Cathartics
- Mechanical irritants
- Endogenous poisons
  - Burns, uremia, gout
- Endocrine

The most important clinical types of chronic colitis form the ulcerative group. The most common types of ulcerative colitis are (a) bacillary dysenteries (b) idiopathic chronic ulcerative colitis (c) amoebic infestation and (d) tuberculosis. Idiopathic chronic ulcerative colitis is a dreadful disease occurring in the prime of life; and is not particularly uncommon. It begins in the rectum in 95% of cases and is thus readily diagnosed by sigmoidoscopy. Sigmoidoscopy is a most important procedure in the diagnosis of colitis. Nevertheless, in certain cases barium enema x-ray studies are indispensable.

FISTULA:—Fistula may be external or internal. External fistula connect some part of the colon with the surface of the abdomen. They result from such causes as a surgical operation, trauma, various ulcerative processes. Internal fistula usually connect colon to colon, or colon to ileum, stomach, bladder or vagina. Gastrocolic fistula most often develops from cancer of the greater curvature of the stomach. Vesicosigmoid fistula usually results from diverticulitis, chronic ulcerative colitis and carcinoma. The x-ray is very useful in the diagnosis. The treatment is essentially surgical.

MEGACOLON:—Megacolon is chronic dilatation of one segment, several segments or the whole colon. The sigmoid is the most frequent site of localized megacolon. The outstanding symptom is obstipation. The diagnosis is confirmed by x-ray and the treatment is essentially surgical.

SARCOMA:—Sarcoma is rare. It has a tendency to form much larger tumors involving larger areas of the bowel than does cancer. Its infiltration of the bowel wall destroys the nerve endings and gross dilatation of the lumen of the segment of the colon occurs. The annular constriction so characteristic of cancer is rarely produced by sarcoma.

BENIGN TUMORS:—Benign tumors, such as fibroma, myoma, lipoma occur rather rarely, and may be confused with carcinoma. However, from a practical clinical standpoint any colonic tumor is to be considered cancerous until microscopic examination of the excised mass proves it to be otherwise.

GRANULOMATOUS LESIONS:—Of the specific granulomatous lesions both syphilis and actinomycosis are rare. However, the possibility of their presence and especially of lues, is to be considered in the diagnosis of colonic lesions. Ulcerative tuberculosis of the rectum or colon will occur in the presence of advanced pulmonary tuberculosis. However, hyperplastic tuberculosis, or tuberculoma, occurs in the absence of advanced tuberculosis in other organs of the body. Tuberculoma is an exceedingly chronic condition, and it may become far advanced before giving rise to definite symptoms. Early symptoms may be those merely of mild dyspepsia, or the onset may be characterized by the severe pain of intestinal obstruction. In other cases the symptoms may simulate appendicitis or gall stone colic. The cardinal symptoms are abdominal pain, loss of weight and diarrhoea; gross hemorrhage is rare. A mild grade of secondary anemia is common and a tumor in the cecal region may be palpable. The ileocecal region is most often involved, and the rectum but seldom. The tumor

is to be differentiated from cancer. If the x-ray barium enema shows simultaneous involvement of the ascending colon, cecum and terminal ileum, then the presence of hyperplastic tuberculosis is probable. Ulcerative tuberculosis is treated medically, while hyperplastic tuberculosis is treated surgically.

Nonspecific infective granulomas are tumor masses composed of granulation tissue. They occur most frequently in the cecal region and often resemble a malignant growth in their appearance both grossly and in the x-ray film after a barium enema. The symptomatology may begin abruptly as an acute inflammatory process. This finding is of aid in differentiating nonspecific granuloma from cancer and hyperplastic tuberculosis. Occasionally the granuloma is readily palpable on physical examination; more often its demonstration can be made only by means of x-ray barium enema. Usually the differential diagnosis between granuloma and cancer can be made only at operation.

Parasitic Infestation:—As you know a number of parasites may infest the bowel; among which amoeba, tapeworm and round worm are familiar to all of you. Infestation with endamoeba histolytica is not a tropical disease, it is world-wide in its distribution. Amoebic infestation occurs probably more frequently than generally supposed because we are not in the habit of examining the stools for the presence of amoeba or amoebic cysts.

Amoebic dysentery is also a type of chronic ulcerative colitis, which is subject to remissions and relapses. The relapses are often characterized by sudden, almost explosive onset of diarrhoea. The diarrhoea consists of fluid stools containing mucous and blood and also shreds of mucous membrane. The abdominal wall is often rigid and tender. Because of the tendency of the disease to localize in the cecum and ascending colon, pain and tenderness in the right iliac fossa may resemble that due to acute appendicitis. Often the acute symptoms begin to subside within a few days. However, if the case is protracted the usual degree of weakness increases greatly and the patient becomes much emaciated and seriously toxic. Fever is variable but in the acute fulminating case may rise to as high as 103°-104° F. Bacillary dysentery may be a complication. When leucocytosis occurs in amoebic colitis it indicates either a mixed infection or the occurrence of a remote complication such as hepatic abscess, peritonitis, etc.

The diagnosis is made by finding the amoeba or its cysts, sometimes sigmoidoscopy is most helpful. Treatment will not be discussed other than to state that emetine hydrochloride remains the most useful drug.

Bacillary Dysentery

As you know many types of dysentery bacilli are recognized. Infection with any of these leads to general systemic symptoms together with severe inflammatory involvement of the mucous membrane of the large bowel; readily discerned by sigmoidoscopy. The diagnosis is confirmed by bacteriological cultural and agglutination methods. The treatment includes the administration of antibacillary serum.

Volvulus and Intussusception

Volvulus of the cecum may resemble appendicitis. Both volvulus and intussusception produce the symptomatology of intestinal obstruction.

Appendicitis

Appendicitis is obviously too large a subject to more than mention in this discussion.

Appendices Epiploicae

The appendices epiploicae are pouches of peritoneum filled with fat. They are subject to inflammations, the symptoms are those of localized peritonitis.

Secondary Disorders of Colon

The mechanisms producing functional disturbances of the large bowel undoubtedly involve numerous and complicated factors. Whatever these factors may be, their end results are largely abnormal changes in muscle tonicity and in sensitivity of reflexes. Such abnormal changes will occur in any clinical condition organic or nonorganic, which affects the muscle of the bowel or its nervous mechanisms. These conditions include all the intrinsic organic affections of the bowel which we have discussed. They include diseases extrinsic to the bowel, as nephritis, cardiac, pulmonary or cerebrospinal affections. They include states of malnutrition and states of chronic fatigue due to either physical or emotional strain. They include factors which locally adversely affect the bowel, such as catharsis or an excessively rough diet. Thus the functional affections of the large bowel are but symptomatological manifestations of underlying disturbances.

Constipation

The failure to recognize that functional bowel affections are but symptoms has led to a vast deal of confusion concerning their clinical significance. The character of this confusion will perhaps be elucidated during a short discussion of constipation. Constipation is the prolonged retention of feces. Among the effects attributed to constipation is a train of symptoms commonly included under the term autointoxication. The whole conception of autointoxication is a nebulous one. It is probably based on the common observation that during the act of defecation unpleasant odors may permeate the atmosphere. These remarks are made to emphasize that the symptoms ascribed to autointoxication are due to something other than constipation. They are frequently the result of the underlying condition causing the constipation.

Many patients' powers of observation are so defective that they erroneously considered themselves constipated. In other words, these patients' brains are less active than their rectums; and as a result they become "colon minded." Therefore, it is essential that the physician learn exactly what the patient means by the term constipation. However, establishing the presence of true constipation does not establish a diagnosis, but merely the presence of a symptom. The next step is to ascertain the underlying clinical condition of which it is a symptom; an outline of these conditions has been discussed.

The treatment of constipation consists primarily of the treatment of the causative clinical condition, and secondarily of the symptomatic treatment of the constipation itself. Thus the character of the causative underlying condition governs largely the character of the therapeutic measures necessary. Therefore consideration of the treatment of constipation is concerned with the field of medicine as a whole. Whatever the underlying cause may be, the treatment of constipation symptomatically can almost invariably be successfully accomplished by simple measures. It is rarely, if ever, necessary to use complicated and spectacular procedures.

Irritable Bowel

Among the functional affections of the large bowel is a condition in which the musculature becomes highly irritable. This condition masquerades under several titles among which mucous or membranous colitis are common. However, colitis is not present although frequently there is a great hypersecretion of mucous. The essential feature is muscular irritability. This condition gives rise to attacks of colicky abdominal pain. Depending on the character of the muscle spasm there will be constipation, or diarrhoea, or constipation alternating with diarrhoea. In making the diagnosis both intrinsic and extrinsic organic diseases must be eliminated. The treatment consists in general physical and mental hygienic measures, a properly balanced diet of bland character, avoidance of drastic cathartics and elimination of such measures as so-called colonic irrigations.

In the diagnosis of affections of the large bowel the importance of the use of the sigmoidoscope and the x-ray can not be over emphasized. However, their use does not obviate the necessity for a painstaking history and a searching physical examination as part of a proper general medical examination.

Old News

A CASE FOR DIAGNOSIS

The Biblical reference to the son of the Shunammite woman has been used by writers of medical literature. Osler and McCrae cited it in their chapter on Sunstroke. Robertson quoted it in a paper on Intracranial Aneurysm. We quote from the King James version; II Kings IV

18 And when the child was grown, it fell on a day, that he went out to his father to the reapers.
19 And he said unto his father, My head, my head. And he said to a lad, Carry him to his mother.
20 And when he had taken him, and brought him to his mother, he sat on her knees till noon, and *then* died.
32 And when Elisha was come into the house, behold, the child was dead, *and* laid upon his bed.
33 He went in therefore, and shut the door upon them twain, and prayed unto the LORD.
34 And he went up, and lay upon the child, and put his mouth upon his mouth, and his eyes upon his eyes, and his hands upon his hands: and he stretched himself upon the child; and the flesh of the child waxed warm.
35 Then he returned, and walked in the house to and fro; and went up, and stretched himself upon him: and the child sneezed seven times, and the child opened his eyes.

Osler and McCrae: Principles and Practice of Medicine, tenth edition. 1930, page 378.
Robertson: Medical Journal of Australia, 2, 381, 1936.

THE RHODE ISLAND MEDICAL JOURNAL
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OSTEOPATHY

Little by little the word is being passed around that osteopaths have the same training as doctors in medicine and have to pass the same state board examinations. Careful scrutinizing of facts, however, will show that these statements are not to be taken at face value.

In the first place osteopathy as it is practised today is not based on demonstrable scientific facts. Many times these so-called dislocations or subluxations when checked by X-rays show absolutely no abnormality. If, as the osteopathic cultists say, all diseases are produced by pressure on the nerves and blood vessels, as these vessels and nerves emerge from the spinal column, and this pressure is caused by a dislocation, at least this dislocation should be demonstrated or felt.

Osteopathy as practised by Still has gradually been broadened until osteopathy may specifically explore various fields of medicine. Thus today you can get an osteopath to treat any disease. State legislators and adherents of the cultists have given them a place in legalized medicine.

Let us for a moment analyze the basic osteopathic training. Riesman[1] points out that the Philadelphia College of Osteopathy, one of the best in the country, gives a four years' course and requires for admission a four years' high school course and one year of college, comparable to what the best medical colleges used to require up to a few years ago.

Etherington[2] visited four of the six approved schools of osteopathy and found that the instructors worked part time only and there was a deficiency of patients for case studies. The schools were run for profit and one of the two best was found to be probably as good as a second-rate medical school of fifteen years ago, rating as a grade C medical school at the present time. The hospital and clinical facilities were entirely inadequate; the requirements for admission and length of courses fell below the standards maintained by medical schools.

In New York graduates of only two schools are able to qualify and 45.5 per cent of these fail to pass the basic requirements.

Franklin H. Martin[3] pointed out that the American College of Surgeons does not give approval to hospitals which extend their privileges to osteopaths. Yet there are hospitals which allow osteopaths to send patients for X-rays and there are physicians who take cases referred to them by osteopaths, to hospitals. Some physicians consult with them. In a certain hospital in a large city, a patient had telegraphed his osteopath in New York to come on to untwist some creak in his neck. The physician in charge sent a telegram to instruct the conductor to tell the osteopath to take the next train back to New York.

Paul Luttinger[4] points out that in California the average osteopath's yearly income is $7,490 and in Philadelphia it is $5,847, far in excess of the yearly averages of regular physicians. He concludes that a large part of the 45 odd million dollars which American consumers pay to osteopaths is wasted on unnecessary and ineffective "manipulative adjustments."

He further states that osteopathy has not made any contributions to scientific medicine except criticism, and that it is fundamentally at variance with scientific medicine, "yet there is a danger in latter-day osteopathy that by its show of adopting the externals of regular medical practice, it tends to persuade the public to regard the osteopath as a healer with adequate medical training. . . . As long as osteopathy subscribes to the tenet of subluxations, it will always remain unscientific, in spite of the lip service its adherents give to scientific medicine. Granted that the courses in osteopathy have been prolonged and the standards raised and its field broadened to include a smattering of everything taught in regular medical schools, osteopathic theory still considers structural derangement as the most important underlying cause of disease."

1. Riesman: The Lancet, 19:515, March 1935.
2. Etherington: J. A. M. A., 104:1549, April 27, 1935.
3. Franklin H. Martin: The Lancet, 19:514, March 1935.
4. Paul Luttinger: Consumer's Research Bulletin, April 1936.

RHODE ISLAND HOSPITAL

Clinical-Pathologic Conference

Tuesday, April 13, 1937

CASE PRESENTED BY DR. CHARLES F. GORMLY

A sixty-one-year-old, white, Armenian male, entered the hospital on January 23, 1937, complaining of weakness, loss of weight, and pain in the left hip. As far as I know, he had had no doctor until this time. He came to us with two separate complaints.

The patient was in good health until about a year before admission when, with no apparent cause, he began to have occasional pains in the left hip. These pains gradually increased in frequency and intensity until November, 1936, since which time he was forced to remain in bed because of his lameness and weakness. The weakness has increased rapidly. The patient stated that he had lost a lot of weight but didn't know how much. For three or four months before entry, he had had the "dry heaves"—rattling, wheezing breathing — and an increasing cough, productive of thick, yellowish sputum with occasional flecks of blood. There was no pain in the chest, no diarrhœa, constipation, nor tarry stools, no urinary symptoms.

Twenty years ago he had gonorrhœa and a penile sore. The past history otherwise was non-contributory. The family history was likewise non-contributory.

Physical examination showed an emaciated though well developed white male, lying in bed. He was very listless. There was no cyanosis nor jaundice. The pupils were equal and regular, reacting to light and to accommodation. The ears and nose were negative. The mouth contained several dirty, carious stumps. The mucous membranes were clear, the throat negative. The thyroid was not felt, the trachea in the mid-line, no lymphadenopathy. The chest was asymmetrical, the right side smaller than the left, expansion on the right limited. Percussion was not hyper-resonant anteriorly but was dull on the right posteriorly, especially at the right base. The breath sounds were everywhere increased, with patchy areas of bronchial breathing and many fine and coarse moist rales and ronchi throughout. The voice sounds varied from normal to nasal in quality. The heart was somewhat enlarged to the left and downward, the rate slow, the rhythm regular, the sounds distinct but of poor quality. No murmurs were heard. The blood pressure was 180/90/. On the abdomen, just to the right of the xiphoid, was a mass two by two cm., slightly tender, seemingly attached to the skin. The patient said that this was of recent origin. The liver was hard, irregularly nodular, and enlarged downwards four or five finger breadths. The spleen was not felt. There was no abdominal pain nor tenderness. The muscles about the left hip and thigh were markedly wasted. There was tenderness over the left sacro-iliac joint and left hip joint with no pain on motion nor limitation of motion of the joint. The rectum was negative. The prostate was small, soft, not tender.

There was nothing remarkable about the blood work. There were 3,650,000 red blood cells, 10,600 white blood cells, the hemoglobin was 74%. The differential blood count showed 80% polymorphonuclear leucocytes, 16% small lymphocytes, 4% large mononuclear leucocytes. The blood urea nitrogen was 24 mg. per 100 cc., creatinine 1.7 mg., glucose 87. The urine showed a specific gravity of 1.018, with albumen, a consistent trace to + 1. The sediment was negative. The Wassermann and Hinton tests were negative.

The X-ray showed a normal heart shadow with slight widening of the supra cardiac region. A dense rounded shadow continuous with the mediastinum suggested a mass at the right hilus region. Throughout the upper three-quarters of the right lung field there was fine mottled increased density with a circular area of increased density overlying the anterior end of the second rib. The left lung was entirely clear. No abnormality appeared in either hip region but there was evidence of considerable bone destruction of the left side of the sacrum and to a slight extent in the adjacent ilium. The exact nature of this bone destruction was difficult to make out because of gas in the intestines. We discussed this case at length with the X-ray department. Dr. Batchelder felt that there was some malignant disease of the lung. Many of the signs were such as we would expect with a bronchiectasis with sufficient blocking off of a large bronchus.

The condition ran a progressively downhill course with low grade afternoon temperature rise up to the ninth hospital day, the pulse running about 100. The patient then became unconscious and incontinent. The temperature gradually rose to 104.5. On the fourteenth hospital day the patient expired. We thought that the patient had either a malignant or a tuberculous lung. His appearance was that of a chest case.

Interpretation of X-ray Films

DR. BATCHELDER: "The lighter areas of increased density" is an unfortunate term. I should have said "ring shadow." Here is the shadow continuous with the mediastinum. You can see, throughout the lung, this very fine mottled density extending through the apex and the base. Then coming to the pelvic film. It shows a large area of destruction in the wing of the sacrum. It is a little questionable whether or not it goes into the wing of the ilium. We asked for further examination which was not done. Stereoscopic films would have enabled us to see the bone more clearly. I don't see any other definite area elsewhere in the pelvic girdle. We have several films of the lower vertebrae. Having heard Dr. Gormly's reading and discussion of the case I think that what I said when I first saw the films still holds. I don't think that by the X-ray we can make a diagnosis between tuberculosis and tumor. There is very little bone reaction about it. In a tuberculosis of a year's duration I should think there would be some chance for a little attempt at repair in some places. In favor of tumor there is this mass in the hilus region but on the other hand this ring-shaped lesion is very suggestive of a small cavity. The sputum could then be explained as a drainage from the infected area.

DR. GORMLY: I think there were one or two negative sputums. His Wassermann was negative despite the story of the sore. I do think that Dr. Batchelder's description of the films would clearly indicate that we did not make a diagnosis. The comparison of the two sides is rather bizarre.

Q.: What was the rate of respiration?

DR. GORMLY: Twenty-five.

Q.: It says here that he had "dry heaves"—I have been accustomed to associate that with a rumbling stomach; is that right?

DR. GORMLY: Yes.

DR. DEWOLF: I want to ask Dr. Batchelder if there is any atelectatic area there?

DR. BATCHELDER: We don't interpret it so. If so there is a very peculiar shaped area of atelectasis. He has quite extensive involvement and very likely some pleural involvement.

DR. DEWOLF: The thing we are all talking about —this wheezing. If you read the books—they all give as the earliest symptoms, wheezing and cough. I saw an article by Jackson in which he said that wheezing over the open mouth is quite indicative of lung tumor. This case shows those early symptoms. Cough, wheezing and later pain in the chest, but he did not have the pain. It seems to me the best guess would be malignant disease of the chest with secondary metastatic involvement in the bones.

Q.: Did he have a big and nodular liver?

A.: Yes.

Q.: Did he have metastatic involvement there?

A.: We suspect that.

DR. DEWOLF: It is quite interesting to note that about 90% of primary carcinomas of the lung are bronchiogenic in origin and come from somewhere in the main bronchus or outside it. Everyone seems agreed that this was in the lung. It is quite interesting to note the lame hip. It seems to me it was primary in the lung and later bone involvement but it appears that the lame hip came first.

I will take this opportunity to tell you about a case I have had, a woman with a primary carcinoma. She had pictures taken, some within two days of her first symptoms. I sent her to Dr. Churchill in Boston and within two or three weeks the woman had collapse of the lung. He did a pneumonectomy and the biopsy at the operative table showed a small bronchiogenic cancer and one little spicule going up to the surface of the lung. This woman was 61 years of age and had been an invalid all her life. She lived through it, got well and just 11 months later had pneumonia in the right lung. Both right lobes were involved but she went through that very successfully. Now two and a half years have gone by and she can do almost everything without too much exertion. Two months ago she came in and said she felt very peculiar in the left side of the face and hands: that is about all that has occurred. There were no glands found at this operation and he got well up on the main bronchus. She weighs 2 lbs. more than last fall. Barring this thing she is pretty well.

Q. Will you say a word about the effect of smoking? In these cases of cancer of the lung, as I take it, most are in males and they are seen in people who use tobacco excessively. What is your own thought about that?

A. I know nothing whatever about it.

DR. CORVESE: I have had two cases of metastatic cancer of the femur, both in females and both heavy smokers. These two cases were primary cancer of the lung with secondary fracture of the femur.

DR. CHAFEE: There was reviewed in the *A.M.A. Journal* an article which showed that cancer of the

lung is definitely on the increase since the war. There was a good deal of discussion as to whether cancer of the lung was not enhanced because of the tar used on the road. I had a tip on the type of cell in this lesion so I looked particularly and the only thing I could find was an article in a German magazine and as I cannot read German I am unable to report it.

Report of Postmortem Findings

DR. CLARKE: At the time of postmortem the man was quite emaciated. In the right axilla and in the right supraclavicular region there were some glands cut down upon which presented a gray, granular, friable material thought to be typical of carcinoma. The peritoneum itself was negative but up in the region of the pancreas was a mass of glands, not a single mass but numerous glands which measured 8 or 10 cm. across. Following down from that were large glands and there was extending into the left sciatic notch and surrounding the sciatic nerve on the left a gray, dense, unencapsulated tissue from which could be scraped a milky substance. Grossly it resembled that in the chest.

Along the trachea are these large lymph glands which are 3 or 4 cm. in diameter. The bulk of the mass is a gray, granular, friable tissue. Here is another large gland located exactly at the bifurcation. Radiating into the substance of the right lung, apparently following along the bronchi is a firm, white, grayish tissue. Here is one large discrete tumor nodule. The remainder of the lung showed a broncho pneumonia which we interpreted as being a fairly terminal affair.

I have here a section through the liver and it is filled with tumor masses. Here is the kidney and there is one little mass, and so there was tumor also in the kidneys.

Then there was this mass described in the pelvis which seemed to invade directly into the underlying bone.

At the time of postmortem all of these tumors were noted and there was much speculation as to which was primary. The bronchi were followed out carefully and there was no place where the mucosa seemed to be actually ulcerated or involved. Here was this large nodule in the lung but no bronchus could be found to communicate with that, nevertheless. It was decided the primary tumor was in the lung.

However, when we saw the microscopic sections it became evident that the gross opinion was wrong. This histology is specific for a type of tumor derived from nervous tissue. These rosettes are unmistakable. They are duplicated in the normal embryology of the adrenal medulla. The most common location of primary tumor of this type is the adrenal medulla. They are also frequently seen in the retina. More rarely cases have been reported in the central nervous system and in the retroperitoneal tissues.

The adrenals and the retinæ in this case were negative. The largest tumor mass was retroperitoneal in the pelvis. The first symptom was pain in the hip. We conclude therefore that this tumor originated from retroperitoneal sympathetic nervous tissue.

DIAGNOSIS: Neurocytoma of retroperitoneal origin with metastases to lungs, liver, kidney and retroperitoneal, mediastinal and axillary lymph glands.

RHODE ISLAND MEDICAL SOCIETY

Minutes of the

One Hundred and Twenty-sixth Annual Sessions

(Continued from Page 134)

Report of the Trustees of the Fiske Fund
One hundred and second year.

Trustees:

JOHN E. DONLEY, M.D.
WALTER C. ROCHELEAU, M.D.
JAMES W. LEECH, M.D. (Deceased)

Secretary to the Trustees:

WILFRED PICKLES, M.D.

June 1, 1937 — First Meeting of the Year

The meeting was held at Dr. Pickles' office and was attended by Drs. Donley, Rocheleau, and Pickles. The response to the announcement of the competition for the year 1936-1937 was very disappointing to the Trustees, and after careful consideration it was decided that no essay submitted met the requirements as laid down by the Trustees and it was voted that no premium be awarded.

It was further voted that a premium of one hundred and fifty dollars be offered for an original essay to be submitted in the contest closing on May 1, 1938, on the subject "Surgery in the Treatment of Disorders of the Autonomic Nervous System". The regulations governing the dissertations were left as in the past few years, and original work and observations are desired.

The secretary was authorized to pay for the care of Dr. Fiske's grave, and to pay to the Catalogue Fund of the Medical Library the emolument awarded to the Trustees by the will of Dr. Fiske.

The usual Financial report was submitted by the Secretary and was accepted by the Trustees.

Respectfully submitted,

WILFRED PICKLES, M.D.,
Secretary to the Trustees.

Report of the Committee on Legislation

There was almost no medical legislation passed at the last session of our State Legislature.

Senate Bill 45, entitled "Crippled Children." This is a part of the Federal Social Security program passed in Washington, January, 1935. This act matches the sum of money allotted by the Federal Government to our State for the care of crippled children.

Senate Bill 125, entitled "Medicines and Poisons." This bill gives the Division of Narcotic Drugs and Pharmacies jurisdiction over the dispensing of barbital compounds or other hypnotics or somnifacient drugs. None of these drugs can be sold except on prescription or given by a physician directly to the patient.

Respectfully submitted,

HERBERT E. HARRIS, M.D., *Chairman.*

Report of the Committee on Maternal Mortality

The committee is still studying the material collected in its five years survey of the maternal mortality in Rhode Island. It expects at a later date to present to this Society its findings and conclusions.

Respectfully submitted,

EDWARD S. BRACKETT, M.D., *Chairman.*

The Association of Military Surgeons of the United States will hold a meeting at Los Angeles, California, on October 14, 15 and 16, 1937. An interesting program will be provided. Lieut. Col. E. C. Moore, 511 South Bonnie Brue, Los Angeles, is the Chairman.

Memorial Hospital

NEW ENGLAND ANESTHETISTS TRAVEL GROUP

The Horace Wells Travel Group of Anesthetists met at the Memorial Hospital on July 31. Present were Drs. Brian C. Sword, New Haven; Ralph M. Tovell, Hartford; I. S. Geetter, New Britain; Charles H. Shamlian, Springfield; George C. Moore, Boston; Russell F. Sheldon, Boston; Sidney C. Wiggin, Boston; Mary A. Leavitt, Holyoke; Albert H. Miller, Providence; John S. Hayward, Providence; Elihu Saklad, Providence; Meyer Saklad, Providence. At the morning sessions, the following demonstrations were given: —By Dr. Miller; Positive pressure nitrous oxide oxygen; Nitrous oxide oxygen ether gravity induction. By Dr. E. Saklad; Cyclopropane oxygen. By Dr. M. Saklad; Spinal anesthesia. The surgical operations were performed by Drs. Frederic V. Hussey, Eliot A. Shaw, and Henry B. Moor. Luncheon was served at the hospital at 1 P. M.

At the afternoon sessions, the following demonstrations were given:—By Dr. E. W. Benjamin; Demonstration of X-Ray films showing the effect of 100% oxygen on intestinal gas. By Dr. Miller; Posture of patients for surgical procedures, with special reference to thyroid and gall bladder surgery. By Dr. E. Saklad; Bacteriologic studies in closed circuit anesthesia apparatus. By Dr. M. Saklad; Demonstration of apparatus for helium oxygen and 100% oxygen therapy. Posture of patients for thoracic surgery with particular attention to a new posture. Consideration of a proposed record keeping system. At 7 P. M. a Rhode Island Clam Bake was served at the Squantum Club.

Dr. Natalie Kechijian has been appointed to the anesthesia service which now gives Dr. Meyer Saklad, chief of service, four staff assistants. This makes for efficiency in the anesthesia department.

A new supervisor has been appointed to act as a liaison officer between the members of the staff and the nursing force, both private and staff nursing, thus making for greater efficiency in the carrying out of recommendations, records, etc.

Dr. E. B. Gammell completed a year's interneship at this hospital on July 31, 1937 and is at present practicing in Hope Valley, R. I.

Dr. Laurence A. Senseman has completed his year's interneship at this hospital and is at present with the Harding Sanatorium, Worthington, Ohio.

Rhode Island Hospital

SCHEDULE FOR SEPTEMBER, 1937

Mondays

10.00 A. M. September 13, 27.
I Surgical Grand Rounds
September 20.
II Surgical Grand Rounds

4.30 P. M. Thoracic Clinic

Tuesdays

9.00 A. M. Gastro-Intestinal Clinic

10.00 A. M. September 7, 21.
I Surgical Grand Rounds
September 14, 28.
II Surgical Grand Rounds

Wednesdays

10.00 A. M. Tumor Clinic

12.00 noon Skin Clinic

Thursdays

9.00 A. M. Orthopedic Grand Rounds

11.00 A. M. Thoracic Clinic

Fridays

11.00 A. M. Fracture Grand Rounds
September 3, 17.
Pediatric Grand Rounds

11.30 A. M. September 10, 24.
Heart Conference

7.30 P. M. September 3.
G. U. Staff Meeting

8.30 P. M. September 3.
Surgical Staff Meeting

Saturdays

9.00 A. M. Neurological Grand Rounds

11.00 A. M. Medical Conference

Dr. Francesco Ronchese sailed for Europe on Thursday, August 19th. He plans to visit France, Italy and Vienna, before he returns in October.

Dr. Ralph Jardine, who finished his interneship on the 1st of August, was married on July 31st to Miss Virginia Walsh in Watertown, Mass. Dr. Jardine plans to start his service at Wallum Lake Sanatorium in September.

Dr. and Mrs. Henry Atha, of Thomaston, Conn., visited the Rhode Island Hospital during this past month.

Dr. Wesley N. Wasgatt, a graduate of Columbia University Medical School, began his interneship on August 15th. Dr. Wasgatt's home is in Rockland, Maine.

Dr. John A. Rodger, a graduate of the University of Syracuse Medical School, began his interneship on July 15th. Dr. Rodger's home is in Moravia, N. Y.

Dr. Charles W. Higgins, Senior Consulting Surgeon of the Department of Gynecology, died on August 19. He passed away quietly as he slept.

Dr. and Mrs. Harry C. Messinger return on September 4 from a trip to London, Paris, and Austria.

Woonsocket Hospital

The regular meeting of the Woonsocket Hospital Staff was held on July 12, 1937, with Dr. T. Frank Kennedy presiding. Dr. Henri E. Gauthier read a paper on "Interpretation of the Schilling Hemogram in Appendicitis" with lantern slides demonstrating his lecture. Two new members were appointed to the medical staff, Drs. Richard Dowling and John Cicchetti.

The July clinical conference was held on the 26th. A case of colitis was presented by Dr. J. Edgar Tanguay and then followed a round-table discussion, Drs. F. J. King, Stephen Emidy, W. A. King, A. Fontaine and G. Dupre participating.

OBITUARY

WILLIAM A. BERNARD, M.D.

Dr. William A. Bernard of Woonsocket, R. I. died July 11, 1937 at the age of 62 years, following an illness of several months duration. He was born in Lowell, Mass., but had been a resident of Woonsocket for many years. He received his medical education at the University of Montreal and was graduated in 1899. He was established in Woonsocket in 1900. For years he was an active member of the Woonsocket District Medical Society and of the Woonsocket Hospital Staff. He served as President of the Woonsocket District Medical Society and had been a member of the Medical Board of the Woonsocket Hospital Staff. He was also a member of the Medical Board of l'Union St. Jean Baptiste d'Amerique. From 1923 to 1925, he served as City Health Officer.

HENRI E. GAUTHIER, M.D.

FIRST "APHORISM" OF HIPPOCRATES

Life is short, and the Art long, the occasion fleeting, experience fallacious, and judgment difficult. The physician must not only be prepared to do what is right himself, but also to make the patient, the attendants, and externals co-operate.

RECENT BOOKS

OPERATIVE SURGERY. By J. Shelton Horsley, M.D., LL.D., F.A.C.S., and Isaac A. Bigger, M.D. With Contributions by C. C. Coleman, M.D., F.A.C.S., John S. Horsley, Jr., M.D., Austin I. Dodson, M.D., F.A.C.S., and Donald M. Faulkner, M.D. Fourth Edition. Two volumes, pp. 1387. With many Illustrations. Cloth, $15. St. Louis, The C. V. Mosby Company, 1937.

For many years the first edition of Dr. J. Shelton Horsley's book "Operative Surgery," published in 1921, has been in constant use by students of surgery as have his later editions, the second edition being published in 1924 and the third edition in 1928. Each edition has been valued for its clearness and simplicity of exposition and the admirably graphic representation of many complex features of the field of operative surgery.

In the first three editions of "Operative Surgery" by Dr. J. Shelton Horsley, the treatise on each occasion was written and edited by Dr. Horsley himself. In the present fourth edition Dr. Horsley has rewritten large parts of the book without, however, sacrificing the many good qualities of his previous editions. He is ably assisted by Dr. I. A. Bigger, Professor of Surgery at the Medical College of Virginia, who acted as co-author and they together give an excellent cross-section picture of operative surgery brought up to date.

To cover the large field of operative surgery as they do in two volumes, the following men collaborated with the authors: Dr. C. C. Coleman, Professor of Neurological Surgery at the Medical College of Virginia wrote on the Surgery of the Central Nervous System and the Cranial Nerves; Dr. A. I. Dodson, Professor of Urology at the Medical College of Virginia, on Urology; Dr. John S. Horsley, Jr., Assistant Professor of Surgery at the Medical College of Virginia, on Plastic Surgery; Dr. Donald M. Faulkner, Associate Orthopedist to the Medical College of Virginia, on Orthopedic Surgery and Dr. Guy W. Horsley gave aid in the preparation of the chapter on Proctology.

This fourth edition follows the same general lines as the other editions and as Dr. Horsley states in the preface of the book, "It does not attempt to be an encyclopedic work." He further states that "Many new operative procedures are described which have not heretofore been published in a book but none has been recommended which does not seem sound."

There are many new chapters such as the chapter on the Surgery of Acute Abdominal Conditions and much of the work in the special fields has not heretofore appeared in any book. Dr. Coleman, Dr. Dodson, Dr. John S. Horsley, Jr. and Dr. Faulkner have all included a number of new procedures in their various specialties, some of which are original with them. The illustrations are numerous and well done.

In dealing with the chapters on General Considerations; Surgical Drainage; Technic, Sutures and Instruments, Dr. Horsley has admirably set forth principles of surgery which every surgeon should know.

"Operative Surgery" is a book which every surgeon should be familiar with, for it is an excellent treatise and can serve as a good reference book and a fine survey of present methods of surgical technic.

ADOLPH W. ECKSTEIN, M.D.

SURGICAL ANATOMY. By Grant Massie, M.B., M.S. (London), F.R.C.S. (Eng.). Third edition, enlarged and revised, pp. 478, with 153 illustrations, many in colors. Cloth, $6.50 net. Lea & Febiger, Washington Square, Philadelphia, 1937.

This hand book of surgical anatomy contains 478 pages of text and 153 illustrations, many of which are colored. The author divides the work into six chapters, the largest of which as would be expected, is devoted to the abdomen and pelvis. In addition to general surgery this book also deals with the surgical anatomy of the eye, ear, nose, throat and autonomic nervous system.

All of the essential points of anatomy relative to the more common operations are covered in a very readable manner, without going into prolonged detailed descriptions. This makes this book a valuable addition to the surgeon's library. What has been said of the text is also true of the illustrations. They are well chosen and easily understandable. As an example of brevity without the sacrifice of important facts, the section dealing with the surgical anatomy of the hand, with special reference to infections, may be cited. Although all sections of the work are admirably done, that which deals with the surgical anatomy of the abdomen is to be especially commended.

J. MURRAY BEARDSLEY, M.D.

SYNOPSIS OF GYNECOLOGY. By Harry S. Crossen, M.D., F.A.C.S., and Robert J. Crossen, M.D. Second Edition, 247 pages, illustrated. Cloth, $3.50. The C. V. Mosby Company, St. Louis, 1937.

This is a concise, pocket sized outline of gynecology based on the senior author's textbook "Diseases of Women." It is intended primarily for the medical student and for the general practitioner who may wish a guide to the leading points in gynecologic examination, diagnosis and treatment without the mass of detail found in the larger textbooks.

The book contains an excellent section on the anatomy and physiology of the pelvic organs, entirely revised since the first edition five years ago because of the rapid advances made in the study of the female hormones, and this is probably its best feature. There are also sections on the general methods of gynecologic examination, gynecologic diagnosis and gynecologic treatment, followed by more specific chapters on the pathology, etiology, symptoms and treatment of the diseases of each of the pelvic organs.

As a clear, brief, well illustrated summary of the common pelvic disturbances, this book is excellent, but of course, it cannot take the place of one of the standard textbooks. The chief criticism that may be leveled at it is the rather small size of the print.

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